Premier's Council on
Health Strategy

ACHIEVING THE VISION: HEALTH HUMAN RESOURCES

REPORT OF THE HEALTH CARE SYSTEM COMMITTEE

A VISION OF HEALTH FOR ONTARIO

We see an Ontario in which people live longer in good health, and disease and disability are progressively reduced. We see people empowered to realize their full health potential through a safe, non-violent environment, adequate income, housing, food and education, and a valued role to play in family, work and the community. We see people having equitable access to affordable and appropriate health care regardless of geography, income, age, gender or cultural background. Finally, we see everyone working together to achieve better health for all.

ONTARIO'S FIRST HEALTH GOALS

Goal 1: Shift the emphasis to health promotion and disease prevention.

Goal 2: Foster strong and supportive families and communities.

Goal 3: Ensure a safe, high quality physical environment.

Goal 4: Increase the number of years of good health for the citizens of Ontario by reducing illness, disability and premature death.

Goal 5: Provide accessible, affordable, appropriate health services for all.

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Roy Aitken, Chair

John Carter
Eleanor Ross
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March 1991

The Honorable Bob Rae
Premier of Ontario
Queen's Park
Toronto, Ontario

Dear Premier:

On behalf of the Health Care System Committee of the Premier's Council on Health Strategy, I am pleased to deliver our second report – *Achieving the Vision: Health Human Resources*. The report recommends a new approach to the way we use, organize, manage and plan for health human resources.

The committee's first report *From Vision to Action*, recommended a strategic plan for Ontario's health care system. The report also underscored the need for managed change in the system and for better utilization of current resources.

It has become clear to us that *people* are the key to implementing the strategic plan for the health care system and ultimately achieving the vision of health.

The direction and recommendations in this report were developed within the context of Council's earlier document – *A Vision of Health: Health Goals for Ontario*. Our work is designed to complement and be consistent with the work of the other committees of Council. We have also continued to balance important values for Ontarians such as access, quality, choice, dignity and cost-effectiveness in health care.

The recommendations are grouped around four key areas which together provide a new approach to the planning and use of health human resources in Ontario.

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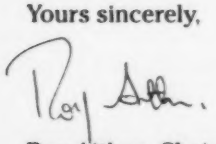
One of the key recommendations addresses the creation of a new planning agency to develop and implement a strategic human resources planning and management capacity for health care. We have recommended a structure and reporting relationship that are designed to bring the key players in health human resources to the table to address the issues and then to give their best advice to government on how to resolve these issues. We have also recommended a strategic human resources planning process which is driven by health goals and needs-based planning. We believe the process is flexible and dynamic and that it can be used at both the provincial and regional levels.

The committee recognizes that there will be many challenges in implementing these recommendations. We do not claim that this report is the perfect answer or even the only answer. However, after extensive consultation and careful deliberation, we believe that it offers recommendations which reflect, as closely as possible, consensus among the public, health care professionals and providers, labour, educators, community organizations, employers and government. We believe that the proposed arrangements will allow and encourage all parties to work together, to achieve the most effective, flexible and cost-efficient use of our key asset – people.

The committee stands ready to assist in any way it can with the publication, explanation and implementation of the recommendations.

Yours sincerely,



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ACKNOWLEDGEMENTS

The Health Care System Committee members wish to express their sincere appreciation and thanks to the numerous individuals who gave of their time and knowledge throughout this study.

The study we commissioned was carried out by Price Waterhouse and provided us with background information to complete our committee report. In addition, John Kettle shared with us his insights into the future and Jim Walker provided the committee with strategic human resources planning expertise.

The work of the committee was also greatly assisted by Dr. Martin Barkin, Deputy Minister of Health; Jay Kaufman, Assistant Deputy Minister, Institutional Health, Michael McEwen, Director of Health Planning and David Hoff, Director of Training and Research, Ministry of Health; Marilyn Knox, Deputy Minister of Tourism and Recreation and Dr. Terry Sullivan, Acting Executive Director, Premier's Council on Health Strategy.

And finally, the committee would like to thank Sue Hyatt for her invaluable work in managing the activities of our committee and for writing this report.

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INTRODUCTION

The Health Care System Committee's first report, *From Vision To Action*, provided a strategic plan for Ontario's future health care system. The four elements of the plan outlined: recommendations for altering hospital funding systems; a more mixed system of remuneration for physicians; strengthened community health and social services; and improved organization and decentralization of health and social services. In the report, the committee underscored the need for better utilization of current resources rather than continuous growth in health care spending. In developing the recommendations, the committee also realized that a human resources plan would be required to accommodate the shifts in health service delivery that would result from its vision of the future system.

Today, the committee is even more committed to the belief that human resources are the single most powerful instrument available to realize its future vision of the health care system and, ultimately, the vision of health for Ontario.

The committee also realizes however, that a whole new approach to the planning and use of health human resources is urgently needed, one which goes beyond the conventional manpower forecasting techniques. We must deal with the inflexibilities and barriers in the system that inhibit the flexible use of our human resources.

Why a whole new approach?

- People make the system function. They are also key to delivering the quality and quantity of health services in the future. Changing funding and incentives in the current health care system, and the shift to community-based health services as an equal partner with the institutional sector, directly affect health care providers and workers throughout the system who are trying to meet the health needs of the population.
- Health care in Ontario is a major sector of the economy and a female-dominated, labour-intensive industry. In 1989, the sector employed approximately 6.5 per cent (277,450 people) of the total employed workforce in Ontario. Of the approximately $15 billion that Ontario spends on health today, 75 to 80 per cent is dedicated to human resources. Better utilization of current resources means that people will have to be deployed in a way that allows them to work much smarter but not harder.
- Over the last decade, health care expenditures in Ontario have increased from approximately 25 to 34 per cent of the provincial budget and are currently growing at twice the rate of inflation. People are the key to making this expenditure manageable.

It is for these reasons that, if we do not change the way we use, organize, manage and plan for health human resources, we will be unable to realize our vision for the health care system.

We consequently need a fresh, new approach to human resources planning and implementation which is driven by health goals, needs-based planning and a flexible and dynamic planning process. This report examines ways in which the public, health care professionals and providers, community organizations, educators, employers, labour and government can work together to achieve the most effective, flexible and cost-efficient use of our key asset – people.

THE VISION – A BLUEPRINT FOR THE FUTURE HEALTH CARE SYSTEM

The strategic directions put forward in the Health Care System Committee's first report, *From Vision to Action*, provide a blueprint for Ontario's health care system in the 21st century. Recommendations were made in four key and interdependent areas: hospital funding systems; physician payment methods; community service development opportunities; and organization and system linkages. These recommendations promote changes in policy directions which translate into the committee's vision for the future health care system.

The committee's vision requires a reorientation of the system from its current predominant focus on the treatment of illness to a more balanced health care approach including an increased emphasis on health promotion, disease prevention and the enhancement of community services. Health care includes health promotion, early detection and monitoring, illness prevention, treatment, rehabilitation and maintenance services. Health care providers encompass all workers in the health care system including community-based workers.

Canada has one of the youngest populations of any country in the world and faces a rapidly aging population with an associated increase in chronic diseases and conditions. This situation highlights the importance of and the need for more rehabilitative care and for more developed, coordinated and accessible community services which will enable people with chronic disease to live as independently as possible. At the other end of the spectrum, we must balance public resources directed to children. The changing nature of the family and women's increased participation in the workforce are causing changes in work and family life which place increasing demands on public resources available for children.

We must find ways to predict costs and better utilize our current resource commitments rather than have continuous growth in health care spending. In order to do more and better with the same resources we must look to the human talent in our health care system. It is essential that we devise a strategic approach to the planning and use of human resources to meet the needs of the future.

A significant departure in human resources planning is needed. It should shift from the compartmentalization of individual professions and from linear projections based on demand or utilization, to an approach which is driven by health goals, needs-based planning and a flexible, dynamic planning process. *From Vision to Action* identified the need for changes in the way we deliver health services. The committee is now also determining that people must be used differently within the system if we are to see such change take place. This fresh, new approach will take strategic human resources planning for health care into the next millennium.

IMPLICATIONS OF THE VISION

The committee's vision of the future has several implications for today's health care system.

INCREASED FOCUS ON COMMUNITY SETTINGS AND REHABILITATION SERVICES

People will need better co-ordinated and accessible treatment and rehabilitation services delivered either in their homes or in community settings. Acute care hospital settings will provide more intensive health care services as an integral part of a strong and co-ordinated continuum of care from home to community to institutional services.

An increase in community settings and changing work environments will also require health care providers to have new skills. Some current providers will need to add new skill sets to their training, and we might also see different kinds of providers developing. The government's Long Term Care Reform initiative, for example, identifies evolving roles for homemakers/attendants and support workers.

MORE EFFICIENT AND EFFECTIVE HEALTH SERVICES

The committee's vision of the future health care system will require changes at all levels of the system to be more efficient and effective in our use of resources to meet health care needs. The infusion of more private or public money at this time is not the answer. We must learn to better utilize current resource commitments. Human resources consequently become a key instrument to consider if we are to "live within our means." Our aim is to deliver quality service with maximum productivity in the system. This requires use of the most appropriate skill sets, at the least cost, to achieve the best patient outcomes. It also means that substitution of skill sets will occur between and within health professional and provider groups.

Organization of Services

- Incentives will encourage more appropriate use of skill sets and reduce duplication of services.
- The use of regional authorities with predictable budget envelopes is being recommended by the Integration and Co-ordination Committee of Council and is intended to contribute to more efficient planning.

  In its report *Local Decision Making for Health and Social Services*, the Integration and Co-ordination Committee recommends that key elements of health and social services be integrated into a local structure and funded by a regional service envelope. These self-managing bodies could operate under some form of appointed or elected local governance.

Service Delivery Organizations

- Acute care hospital settings will be the focus of more intensive and acute health care services. There will continue to be pressures to increase costs in the system. Technological change in health care, for example, is often associated with increased costs. These pressures need to be balanced with better utilization of our current resource commitments rather than continuous growth in health care spending.
- The committee previously recommended caseload-sensitive global funding as the core method for funding of hospitals. It allows easier comparisons and cost predictability for government and the potential for flexibility in hospital expenditure patterns. A case-mix approach recognizes differences in hospital workloads and encourages greater efficiencies within the organization.
- The committee has reaffirmed its belief in a mixed system of remuneration for physicians. Fee-for-service and solo practice can be part of a blended system along with the expanded use of alternative funding and organization mechanisms such as Comprehensive Health Organizations (CHOs), Community Health Centres (CHCs) and Health Service Organizations (HSOs). Such reorganization offers opportunities for more efficient service, more appropriate substitution of personnel

and for community input on the range and type of services that would meet the health needs of the community.

- All delivery organizations should strive for continuous quality improvements using quality assurance mechanisms as an integrated part of the process. Continuous quality improvements also signal significant implications for labour and management processes in the health system.

Individual Practitioners

- Individual practitioners have a responsibility to ensure that they perform necessary procedures to improve health outcomes and that the procedures are performed in an effective and efficient manner. There are opportunities to improve efficiency and effectiveness in individual practices. The Task Force on the Use and Provision of Medical Services (Ontario), for example, has reviewed treatment approaches to asymptomatic hypercholesterolemia and states that the "best approach to the detection and management of cholesterol should be based on the individual health circumstances of people."
- In relation to the Ontario Health Insurance fee schedule, there are opportunities for members of the medical and other professions, to incorporate incentives for efficiency, effectiveness and a shift to community-based care. If a number of procedures can be performed safely, effectively and at less cost in an outpatient setting, for example, then incentives could be provided to perform those procedures in the most cost-efficient setting.

CHANGES IN GOVERNANCE AND MANAGEMENT

- The organization and management of the future health care system will change significantly based on the vision. The governance and management of health care delivery settings will also change incorporating more consumer participation and improved equity among the various health providers.

CHANGES IN EDUCATION AND TRAINING

- The implications outlined above highlight education and training needs throughout the system. Adequate training of health professionals must reflect the substantial reforms under way in the health care system. As part of a comprehensive needs-based approach to human resources planning, health science centres, community colleges and other training programs must develop curricula more directly oriented to their local communities and the population health needs in Ontario. Measures should be taken to assist the development of a health intelligence capability to link epidemiological data, cost, and delivery systems to health outcomes and human resources planning with a particular community college or university.

  Community and multidisciplinary practice settings should be added to current training sites to give students actual experience in a full range of delivery systems. All health students need to understand, and to be trained in cost and resource management and the need for affordability and cost predictability in the health care system.
- Health science centres and community colleges play an important role in health human resources planning. Universities, which are responsible for producing many key categories of health professionals, are generally funded on a global basis. In future, universities need to be more directly accountable, responsive and provide better levels of adjustment for graduating health professionals within an overall strategic health human resources planning process.

  The Ministry of Health has been able to influence the total volumes for training of particular professions in few areas. Notable exceptions include: measures to increase the training capacity for rehabilitation professionals through additional dedicated funding for related university programs; and the recent collaboration with the Council of

Ontario Faculties of Medicine (COFM) to reduce modestly the growth of physician specialist training by reducing the number of residency positions which are funded directly by the Ministry of Health.

- New measures need to be taken to build equity and co-operation among various professions. One way of doing this would be common or generic, basic educational building blocks for all health professionals. Benefits gained from this approach to common curriculum elements would include a better understanding of roles and would contribute to easier substitutability of skills. In addition, interprofessional co-operation at a project level early in the curriculum will go a long way to improving collaboration in the workplace.
- It will also be necessary to develop retraining strategies to facilitate the potential reassignment of some health care workers to areas of greater need. With a shift to home-based and community settings, for example, different skills will be required of both workers and management personnel. In areas with an acknowledged surplus of physicians, for example, incentives that would convert a modest number of fee-for-service practitioners to salaried health services researchers at a fair proportion of their former incomes might be considered.
- There is a critical need to bolster health system delivery research on issues such as: alternate delivery methods; cost and resource management; and quality management – including efficiency and effectiveness of services. Building an infrastructure in the health science centres for evaluation and health services research goes hand in hand with building needs-based planning for human resources.
- Public education and awareness and a willingness to participate in the changes will also be key to creating a receptive climate for improved efficiencies, effectiveness and quality in the system.

IMPROVED MIX AND DISTRIBUTION OF HEALTH CARE PROVIDERS

- Oversupplies and undersupplies of personnel need to be adjusted to provide a more appropriate mix, use and distribution of health human resources.
- An improved mix, use and distribution of personnel will make an essential contribution to increased productivity in the workforce.

CONTINUOUS QUALITY IMPROVEMENT LEADING TO GREATER PRODUCTIVITY

- Human resources issues affect all sectors and countries. Some of the lessons learned in other jurisdictions can be applied to human resources planning for health. A turbulent operating environment is changing the nature of competition in the private sector. Price, quality and service are key supports of competition and are heavily influenced by excellence in operations. What determines excellence in operations? People are the key ingredient. People use their organizational tools and resources to their best advantage.

  How do we release the untapped imagination and potential of the health care workforce? All sectors of the competitive workforce are struggling with similar questions. The health sector can learn a great deal from modern management science – and particularly from the Japanese and American experience in the total quality management of individuals and organizations. From this experience, we can build our own unique approach in co-operation with all stakeholders and provider groups.
- One method of the total quality management of individuals and organizations is the concept of continuous quality improvement promoted by D.M. Berwick affiliated with the Harvard Community Health Plan and others. Continuous improvement is the merging of productivity, quality and customer service into an integrated effort to use the creativity and discipline of all people. Working in teams,

people can improve the excellence of operations. The Japanese refer to this process as *kaizen* and it is equally applicable to manufacturing or service operations.

Continuous quality improvement includes teamwork in everything; customer or patient satisfaction; a total quality approach; employee empowerment; automation; innovation by everybody; management through vision and values; strategic choices; developing core competencies; and focusing on the interdependencies in the organization.

- There is a high degree of autonomy and self-management within the health professions. One of the principles identified in health human resources planning is the reconciliation of the scopes of professional practice with quality management and productivity needs. Professional colleges/regulatory boards and associations can play a greater role in promoting quality management and increased productivity. The colleges/regulatory boards have a legitimate supervisory role in serving the public interest. They could also serve the public interest further, however, by encouraging their members to strive for measurable continuous improvement in their practices. The work of the Task Force on the Use and Provision of Medical Services (Ontario), a joint effort by the Ministry of Health and the Ontario Medical Association, is an example of initial steps in this direction. Likewise, the role of the College of Physicians and Surgeons of Ontario in establishing quality assurance mechanisms under the Independent Health Facilities Act represents another step in this direction.

As the committee envisioned the future health care system, and as it reviewed the implications of that vision, a goal and guiding principles for human resources planning in health began to emerge.

GOAL FOR HUMAN RESOURCES PLANNING IN HEALTH

The goal of human resources planning in health is to achieve the most effective, flexible and cost-efficient use of our key asset, people, in order to realize Ontario's vision of health.

The committee's approach to planning addresses both planning *and* use: *planning* for the correct numbers, mix and distribution of people and their skills; and *using* people's skills optimally through flexible and empowering organizational and management techniques.

Human resources planning is an ongoing, multidimensional interaction among the various stakeholders. It is not a case of an ideal structure driving the planning for human resources, or a planning process driving the structure: it is rather a dynamic interaction of structure and process.

GUIDING PRINCIPLES FOR HUMAN RESOURCES PLANNING IN HEALTH

We believe that health human resources planning should be guided by the following principles:

1. Human resources planning is *the most important component of strategic planning* in health care and a fundamental component of health policy.
2. *Human resources planning should be driven by health goals.* The implication is that planning begins to be driven by health outcomes based on the health needs of the population.
3. The health human resources planning process should be *dynamic and flexible* enough to anticipate issues, monitor trends and respond effectively in a rapidly changing environment.
4. Human resources *substitutions* will need to occur between, and within health care provider groups in order to achieve quality health service with maximum productivity. The most appropriate skill set required at the least cost to achieve the best patient outcome is the most desirable result of such substitutions.
5. Future efforts in health care should be driven by *better utilization of our current resources.*
6. Commitment to *continuous improvements in health care* is essential and assumes that not all health care services performed today are appropriate or equally effective.
7. Health human resources planning should be *open to public scrutiny*, be consultative and have multipartite involvement.
8. Provincial development of a strategic human resources planning capability must be *strongly linked to federal and regional planning. Ontario has an opportunity to play a leadership role* in developing a national strategy for health human resources planning.

FUNDAMENTAL HEALTH HUMAN RESOURCES ISSUES

Given that health care is a major sector of the economy and a female-dominated, labour-intensive industry in which human resources costs consume 75 - 80 per cent of the approximately $15 billion that Ontario spends on health, we need better utilization of our current resources to help manage the continuous growth in health care spending. Specifically, we must look to the human talent in our health care system and devise a strategic approach to human resources planning and using people's skills to meet the needs of the future. It is no longer sufficient to track the current number and distribution of providers and to make projections based on historical growth rates.

The key issue is how to improve the effectiveness and efficiency in the health care system through more flexible use and substitution of human resources. Specifically, we must find ways to overcome the barriers identified in the inter-related policy areas of human resources planning and supply, governance and regulation, and funding and service delivery methods. The current vertical organization of professions and government ministries and how they are managed, inhibits the flexible use of people and their skills. The case study in Appendix 5 demonstrates an example of how skill sets provided by nurse practitioners can be substituted for some activities of family physicians in order to deliver quality service at less cost to the system.

Secondly, there is no clearly defined locus of responsibility for health human resources planning and decision making at the federal, provincial or regional levels. Steps must be taken to remedy this situation at the provincial and regional levels and to influence action at the federal level. It is essential that a provincial body take a leadership role in addressing barriers to change and bottlenecks within the system so that change can occur.

A third issue identified by the background study conducted for this report is that there are a number of health care provider categories where numbers of personnel do not match the projected need. Examples include: physicians; nurses; rehabilitation personnel including physiotherapists, occupational therapists, speech language pathologists and audiologists; home workers such as homemakers; specialty technical workers such as cardiac perfusionists and radiation technologists. Further planning efforts will have to recommend policy directions to redress this mismatch of numbers and mix.

Fourthly, reliable, consistent and co-ordinated data are necessary to support health human resources planning. There should be a centralized thrust to co-ordinate data already available and to develop reasonably accurate data where necessary. More importantly, the data should be generally accepted for use in making planning decisions.

Fifthly, when planning, it is essential to conduct needs-based planning driven by health goals. Needs-based planning is dependent on data that identifies population health needs. It is recognized that much of this information is in the early stages of development.

And finally, the health labour force has several features that distinguish it from normal market interactions in the rest of the labour force.

- It is characterized by a large professional pool with well established territorial relationships within and among the different groups.
- There is a high degree of autonomy and self-management within the health professions and it is possible for the legal boundaries of professional practice to come into conflict with the employers' needs for quality management and productivity.
- There are long training periods for many of the professions creating time lags between modifying education and training strategies and realizing results.
- Most health services are not provided on a market basis. Employment within the health care industry is recession proof. Insured users do not pay at the time of service and price does not influence demand. Professionals and consumers both play a role in creating demand for service.

THE MEANS TO CREATE CHANGE

How do you influence, stimulate and create change in a complex and rapidly changing health care environment? What sort of structure and process for planning and implementing changes in health human resources can be established which will deliver needs-based planning driven by health goals and the health needs of the community?

In this report, the committee has identified its vision of what the future health care system might look like. As a result of broad consultations, the Health Care System Committee has drawn several implications for human resources planning in health and has developed goals and principles for planning as a guide to addressing the fundamental issues. We have identified what we believe to be key features of change that will anchor the development of a structure and process for health human resources planning. These features are as follows:

1. A locus of provincial responsibility for health human resources planning and a lead minister for decision making at the provincial level are needed.
2. A planning process based on population health needs with clear consumer participation and open to public scrutiny and debate can result in consensus.
3. This process should have a strategic focus based on our human resources planning principles. Recommendations will identify policy directions for the future and how these directions can be implemented. An annual public report will assess how well the implementation has been achieved.
4. Partnership and equality among stakeholders within the planning structure and process will contribute to a far superior system.
5. Dispassionate analysis of data will achieve a general acceptance of data for planning purposes.

Using these features to lay a foundation for change, the committee is recommending a new approach to health human resources planning in Ontario.

RESPONSIBILITY FOR PROVINCIAL HEALTH HUMAN RESOURCES PLANNING

Health human resources planning and management is interrelated among numerous stakeholders and crosses many jurisdictional and interministerial lines.

Exhibit A illustrates key policy levers in the planning and use of health human resources and identifies the diversity of responsibility for those levers.

The Health Care System Committee recommends, therefore, that the locus of provincial responsibility for health human resources planning should rest with a lead minister of a pivotal central agency of government – such as Management Board of Cabinet or Treasury and Economics. The lead minister should be a member of a designated cabinet committee responsible for health resources and for revising and monitoring provincial health goals and objectives. Committee membership should reflect crossministerial involvement in or responsibility for human resources planning. Ministers that should be included on the committee are: Health, Community and Social Services, Colleges and Universities, Treasury and Economics, and Labour, and other ministries as deemed appropriate.

The committee further recommends that a new Health Human Resources Planning Agency (HHRPA) be established in Ontario. The lead minister and the cabinet committee should be guided in their actions by the new agency that will have a specific mandate to develop and implement a strategic health human resources planning and management capability.

EXHIBIT A
POLICY LEVERS FOR STRATEGIC HEALTH HUMAN RESOURCES PLANNING

POLICY LEVERS	RESPONSIBILITY
Human Resources Planning and Supply	
• Enrolment levels	• Institutions for higher education
• Education - curricula	• Institutions for higher education, professional associations, colleges
• Funding for training	• Ministries of Health, Colleges and Universities, Community and Social Services
• Recruitment processes	• Employers, Ministry of Health
• Retention processes	• Employers, professional associations, Ministry of Health, labour
• Redeployment and retirement processes	• Employers
• Career counselling and marketing of professional careers	• Employers, Ministries of Education and Skills Development
• Retraining	• Employers, Ministry of Colleges and Universities
• Immigration incentives and regulation	• Immigration Canada, Ministry of Health
• Collective agreements	• Employers, labour
• Job design	• Employers
Governance and Regulation	
Professional	
• Scope of practice	• Provincial legislation, professional colleges
• Professional licensure	• Professional colleges
• Competency testing	• Professional colleges
Service Delivery	
• Institutions, agencies, and other organizations	• Provincial legislation
Funding and Service Delivery	
• Remuneration levels	• Employers, funding agencies/ministries
• Remuneration methods	• Ministries of Health and Community and Social Services, labour, providers, employers
• Practice location incentives and regulations	• Ministries of Health, Community and Social Services
• Service delivery models	• Providers, Ministries of Health, Community and Social Services

RECOMMENDED STRUCTURE FOR A PROVINCIAL HEALTH HUMAN RESOURCES PLANNING AGENCY (HHRPA)

The mission of the agency will be to achieve the most effective, flexible and cost-efficient use of our key asset, people, in order to realize Ontario's vision of health. The agency's reporting relationships, mission and mandate should be set out in legislation.

The mandate of the HHRPA will be to develop a strategic human resources planning and management capability for health care. The agency will then make recommendations to government on human resources policy directions in health and recommend strategies to implement those policy directions. To carry out its mandate the agency will:

- access and analyze appropriate health human resources data;
- track health human resources trends;
- identify current issues that inhibit the flexible use of all health human resources;
- determine goal-driven human resources requirements;
- identify ways to achieve the right mix, use and distribution of health personnel;
- give strategic advice on specific policy directions in health human resources planning;
- make recommendations on strategies to implement policy directions;
- evaluate and monitor the implementation of the recommendations, their interactions and the planning process; and
- publish an annual public report.

It is recommended that the activities of the Health Human Resources Planning Agency be directed by a council consisting of key stakeholders involved in health human resources planning. A full-time chairperson with an impartial background should be appointed. The membership of the council should be no greater than 20 part-time members who are appointed to a three-year term with one possible renewal of term, allowing for rotational change. The council will be a multipartite body and have representation from the following groups:

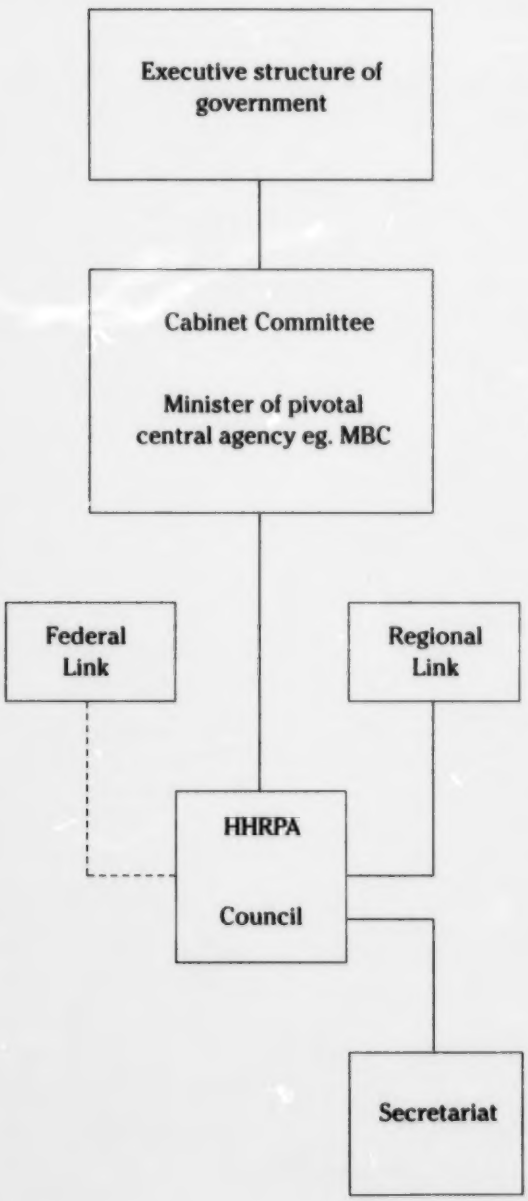
- consumer/public interest representatives;
- employers representing traditional and alternative delivery settings;
- health professions and occupations including labour representation to a maximum of 25 per cent of the total membership;
- health educators including representation from health science centres, community colleges and other health education programs to a maximum of 20 per cent of the total membership;
- senior ministry representatives from key ministries including Health, Community and Social Services, Colleges and Universities, Labour and other ministries that the government may deem appropriate, to a maximum of 25 per cent of the total membership;
- one member of the proposed Ontario Training and Adjustment Board (OTAB)[1];
- one member with strategic human resources planning expertise; and
- the above members would reflect a balance in regional representation from across the province.

The HHRPA would publish an annual public report outlining: a planning analysis of health human resources and issues in Ontario; recommendations to address current issues; and an evaluation of the implementation of previous recommendations made by the agency.

A secretariat would be created and given sufficient funds to support the work of the HHRPA. Activities would include addressing current health human resources issues; co-ordination and analysis of existing data and implementing measures to develop new data as required; consultation with various stakeholders; stimulating change projects; and the preparation of reports.

EXHIBIT B
THE HEALTH HUMAN RESOURCES PLANNING AGENCY - STRUCTURE

STRUCTURE



ROLE

CABINET COMMITTEE

- Broad mandate for health resources and human resources planning and use.
- Examples of Ministers participating: Health, Community and Social Services, Colleges and Universities, Treasury and Economics, and Labour

HHRPA

Mission

- To achieve the most effective, flexible and cost-efficient use of our key asset, people.

Mandate

- To develop a strategic human resources planning and management capability for health care.

Reporting Relationship

- Reports to the appropriate cabinet committee via the minister of a pivotal central agency of government e.g. Management Board of Cabinet (MBC)

Council

- Chairperson
  - Full time
  - Impartial background
- Membership
  - 20 part-time members
  - Appointed to 3-year term (1 possible renewal)
  - Multipartite membership
    - . consumer/public interest
    - . employers
    - . health professions and occupations including labour (max. 25%)
    - . health educators (max. 20%)
    - . senior Ministry officials (max. 25%)
    - . proposed OTAB representative
    - . strategic human resources planning expertise
    - . regional representation

Product

- Annual Report
  - Planning analysis
  - Recommendations
  - Evaluation of implementations and recommendations

Secretariat

- To support the work of the HHRPA
  - Identify issues
  - Data co-ordination and analysis
  - Consultation
  - Stimulating change projects
  - Preparation of reports

Exhibit B summarizes the structure and role of the recommended Health Human Resources Planning Agency and its reporting relationships described above.

PROVINCIAL LEADERSHIP IN HEALTH HUMAN RESOURCES PLANNING LINKS WITH FEDERAL AND REGIONAL ROLES

Comprehensive provincial health human resources planning cannot be done in isolation. Provincial planning has national and regional implications and must be strongly linked to such planning activities.

A national co-ordinating policy in health human resources planning is needed. Ontario does not operate health services in a closed market. Key federal and interprovincial arrangements influence our health human resources labour market directly. Federal immigration policies and interprovincial co-operation and agreements on training for various categories of health professionals have a direct impact on our supply of human resources and influence provincial human resources planning.

As we press for federal and interprovincial action, we believe that Ontario must ensure that the interests of Ontario's citizens are primary. The committee does not believe that Ontario should strive for complete self sufficiency in health personnel. It believes that the province should establish flexible targets based on provincial planning and build on a combination of market forces and supply levers.

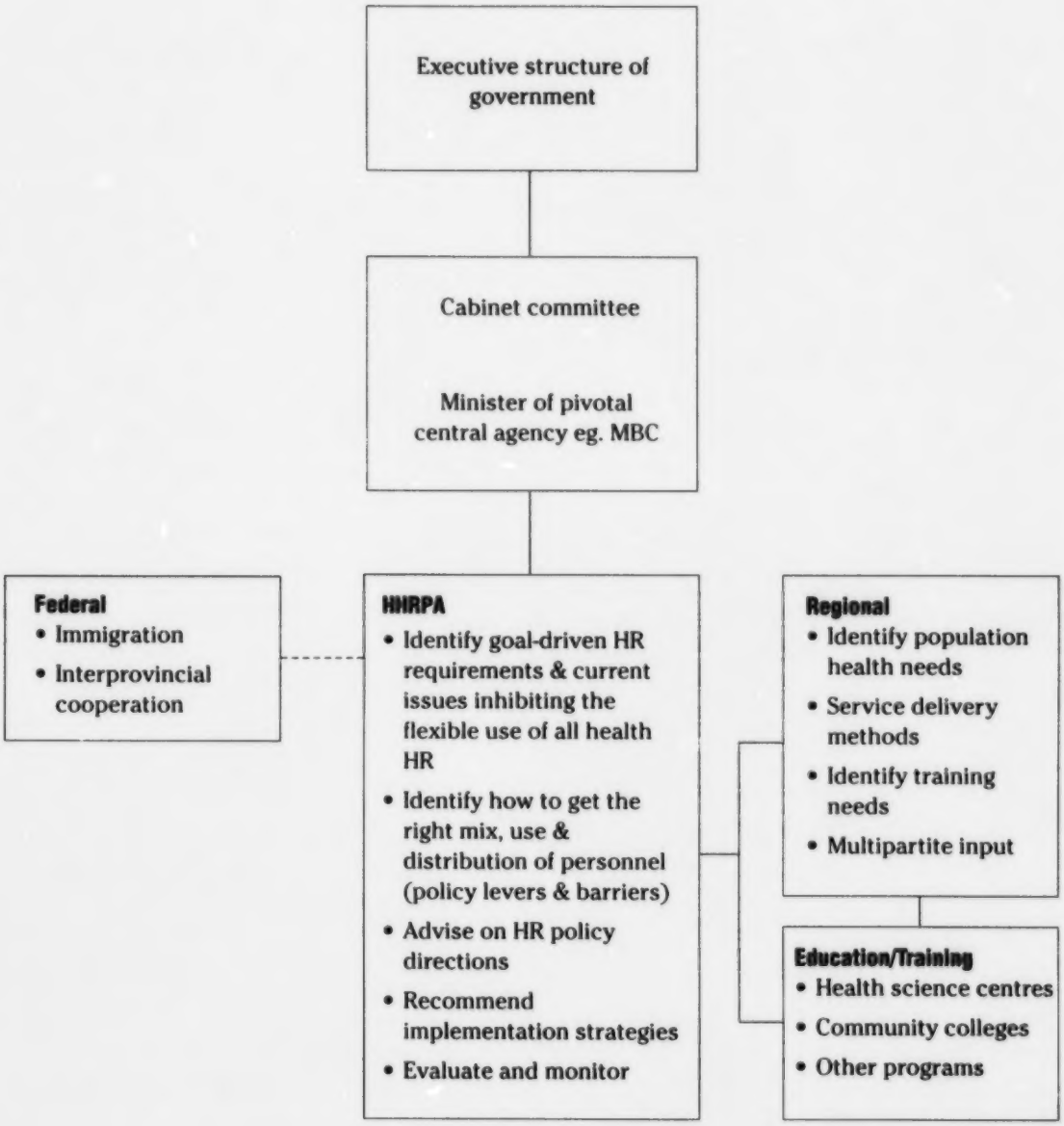
Where Ontario benefits as a net recipient of some categories of well-trained professionals from other provinces, we should build our planning targets with this migration in mind. Because Ontario is a net recipient, we do not need to train as many professionals as we do. If a shortage occurs because of migration out of Ontario, then market forces must be brought to bear, particularly in the area of working conditions and compensation. Remuneration and working conditions can be adjusted in the deficient area to attract the numbers of individuals needed. This should be a key planning consideration in training for Ontario's needs.

Building on a combination of market and supply forces initially at the provincial level, the same approach can be brought to bear at the regional and interregional level with provincial co-ordination. Such an approach highlights again the importance of regional planning. The Integration and Co-ordination Committee of the Premier's Council has recommended an enhanced role for the planning and management of resource allocations at the regional level. Needs-based planning in health human resources links population health needs with service delivery methods at the regional level. Once population health needs are known and matched with available service delivery, regions would also be able to identify training needs for their areas. Regions would then be able to develop their own human resources plans and this would lead to greater flexibility in the regions based on local health needs while recognizing the overriding need for provincial co-ordination and integration. A review of planning roles at the provincial and regional levels has revealed the need to focus on the education of health professionals and providers.

Educators are key stakeholders in the health human resources planning process. Their enhanced participation in the planning process will help to achieve greater accountability for the outcome of education programs. Educators, including representatives from universities, colleges and other training programs, should actively participate in health human resources planning at all levels. We are recommending that educators be one of the constituencies represented at the Health Human Resources Planning Agency. Educators should also participate in human resources planning activities at the regional level.

The following schematic is a summary of federal, provincial and regional roles in health human resources planning. The education/training component is introduced as an integral player with the HHRPA and the regional level.

EXHIBIT C
THE HEALTH HUMAN RESOURCES PLANNING AGENCY – ROLES IDENTIFIED


Executive structure of government
Cabinet committee
Minister of pivotal central agency eg. MBC
Federal
• Immigration
• Interprovincial cooperation
HHRPA
• Identify goal-driven HR requirements & current issues inhibiting the flexible use of all health HR
• Identify how to get the right mix, use & distribution of personnel (policy levers & barriers)
• Advise on HR policy directions
• Recommend implementation strategies
• Evaluate and monitor
Regional
• Identify population health needs
• Service delivery methods
• Identify training needs
• Multipartite input
Education/Training
• Health science centres
• Community colleges
• Other programs

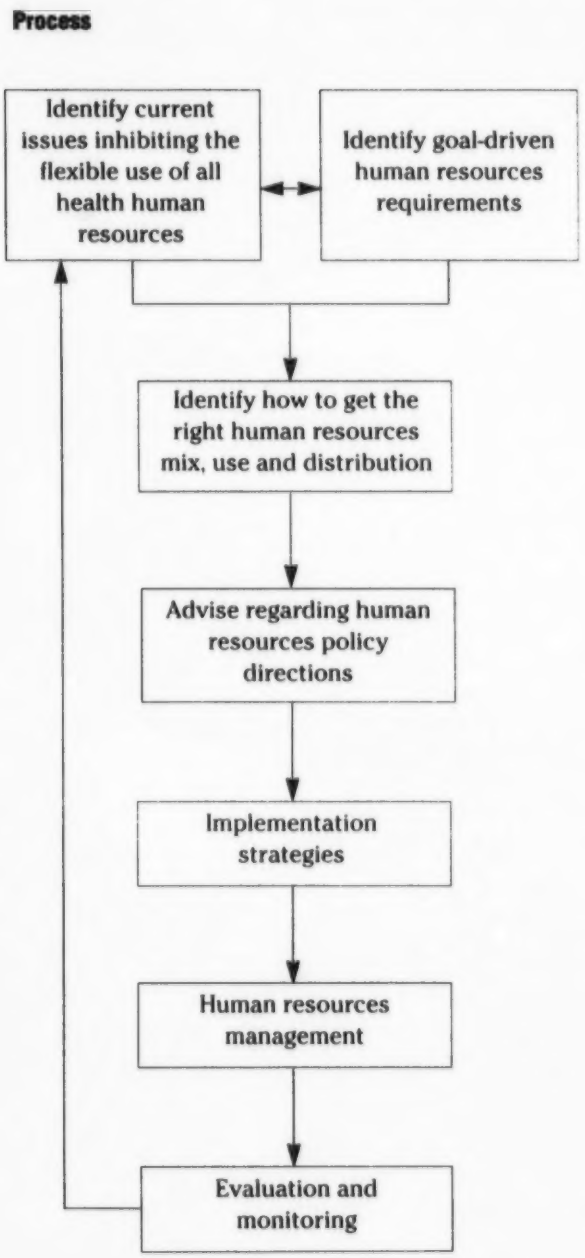
We have reviewed the proposed structure for the Health Human Resources Planning Agency and the associated federal, regional and education/training roles. The next step is to review the strategic planning process that the HHRPA and others would undertake.

THE RECOMMENDED STRATEGIC HEALTH HUMAN RESOURCES PLANNING PROCESS

Our intent is to create a strategic human resources planning and implementation capacity for the health care system.

An overview of the strategic human resources planning process that we are recommending is provided in Exhibit D. It identifies the different processes involved, who has responsibility, and what role the HHRPA should play. The process begins by identifying the goal-driven health human resources requirements and current issues inhibiting the flexible use of resources and ends with the evaluation and monitoring of recommendations.

EXHIBIT D
THE STRATEGIC HEALTH HUMAN RESOURCES PLANNING PROCESS



Identify Current Issues and Goal-Driven Human Resources Requirements

The committee recommends a "twin track" approach to the planning process. On one hand, identification of the net human resources requirements will be based on population health needs and driven by the health goals: on the other, we also need to identify current issues that inhibit greater flexibility in the use of all health human resources.

By "needs-based" planning we mean an epidemiologically based approach to identifying and measuring health status deficits. This approach also involves consideration of the *appropriateness* of health care services in managing those deficits. Appropriateness of services includes the dimensions of *availability, effectiveness* and *efficiency.* Availability refers to the availability of current knowledge and technology being able to alleviate the identified health status deficit. The other dimensions are the effectiveness and the efficiency with which an intervention is used to manage the health status deficit.

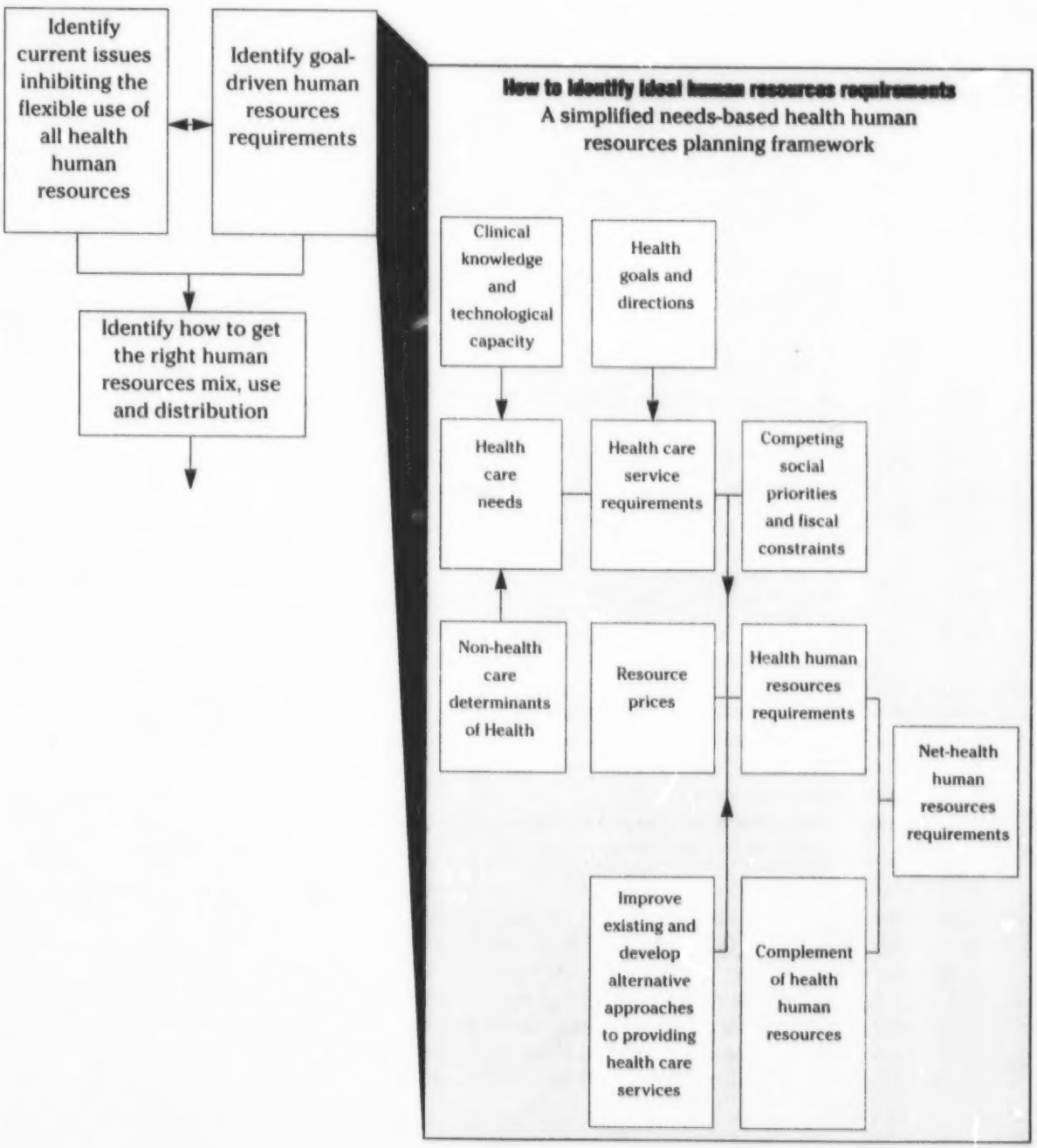
Needs-based planning is another way of thinking about the gap between our health goals and objectives and our current health status. The comprehensive or "guiding" part of this approach attempts to integrate health goals with alternative service approaches and competing priorities and dollars. Needs-based planning is tied directly to local service delivery models, the population health needs of a given region, and to productivity.

The simplified needs-based health human resources planning framework illustrated in Exhibit E is the framework that allows us to identify human resources requirements that are driven by provincial health goals. The framework is driven by population health needs, health goals, costs and alternative approaches to delivery along with our knowledge of effective treatments.

The committee is well aware that not all of the components identified in the planning framework are readily available. That is why the committee feels the process will inevitably be driven by current issues inhibiting the flexible use of our human resources but balanced against this ideal framework. The committee is proposing, however, that this is a viable framework for determining future health human resources requirements. One of the first tasks of the HHRPA would be to take steps to implement this framework and to begin to co-ordinate and direct the development of data necessary to support the framework.

EXHIBIT E
THE STRATEGIC HEALTH HUMAN RESOURCES PLANNING PROCESS

Process


Identify current issues inhibiting the flexible use of all health human resources
Identify goal-driven human resources requirements
Identify how to get the right human resources mix, use and distribution
How to identify ideal human resources requirements
A simplified needs-based health human resources planning framework
Clinical knowledge and technological capacity
Health goals and directions
Health care needs
Health care service requirements
Competing social priorities and fiscal constraints
Non-health care determinants of Health
Resource prices
Health human resources requirements
Net-health human resources requirements
Improve existing and develop alternative approaches to providing health care services
Complement of health human resources

Identify Ways to Achieve the Right Mix, Use and Distribution of Human Resources

Identification of both the net human resources requirements and the current and pragmatic issues that inhibit more flexible use of human resources provides the basic information that is needed to identify ways to achieve the right mix, use and distribution of human resources. By analyzing the policy levers, reviewing who has responsibility for the levers and identifying barriers that prevent the effective use of the policy levers, it is possible to identify how the most appropriate mix, use and distribution of people in the system will be achieved. Exhibit F provides a summary of this step.

Analysis of policy levers and how they function is a complex task and will need a great deal of attention in the future. To illustrate what this approach might entail, Appendix 5 outlines a brief case study on nurse practitioners in Ontario. It identifies the barriers hampering the increased use of nurse practitioners and explores policy levers that could be manipulated to overcome these barriers and allow nurse practitioners to perform some of the activities currently provided by family physicians.

Advise on Human Resources Policy Directions

Having identified what the human resources requirements are and how the right mix, use and distribution of human resources in health will be achieved, the next step for the HHRPA is to give strategic advice on policy directions that indicate how the policy levers should be pulled differently and the barriers to be addressed.

Recommend Strategies to Implement the Policy Directions

The strategies will identify the application of relevant policy levers depending on the issues and human resources requirements. The strategies will also identify who is responsible for the policy lever and who should operate the lever. The intention is to remove barriers that prevent more flexible use of personnel. Time frames for implementation and evaluation of the effectiveness of the interventions should also be identified.

Facilitate Human Resources Management Strategies

Management plans are the responsibility of other designated players including government ministries, employers, educators and regional structures.

Evaluate and Monitor

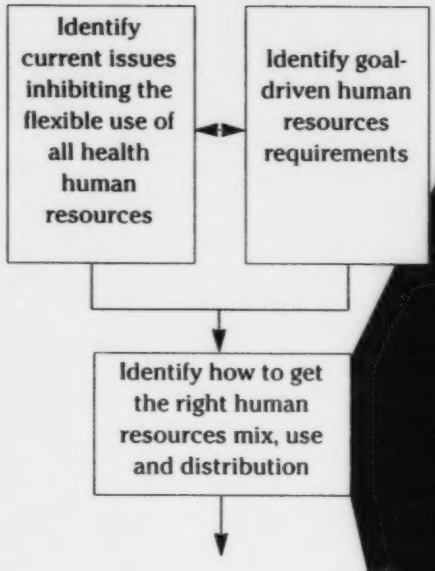
The final step is the evaluation and monitoring of the process and its outcomes.

The recommended HHRPA structure and planning process will, in itself, encourage evaluation by:

- submitting the process to public scrutiny and encouraging open debate by presenting an annual report which includes a planning analysis, recommendations on policy directions and implementation strategies, and an evaluation of previous recommendations and their implementation;
- facilitating the adoption of new policy directions;
- facilitating the translation of those new policy directions into implementation strategies for human resources management; and
- closing the evaluation loop, monitoring the feedback on recommendations and actions taken, and making adjustments as necessary.

EXHIBIT F
THE STRATEGIC HEALTH HUMAN RESOURCES PLANNING PROCESS

Process


Identify current issues inhibiting the flexible use of all health human resources
Identify goal-driven human resources requirements
Identify how to get the right human resources mix, use and distribution

POLICY LEVERS FOR STRATEGIC HEALTH HUMAN RESOURCES PLANNING

POLICY LEVERS	RESPONSIBILITY
Human Resources Planning and Supply	
• Enrolment levels	• Institutions for higher education
• Education - curricula	• Institutions for higher education, professional associations and colleges
• Funding for training	• Ministries of Health, Colleges and Universities, Community and Social Services
• Recruitment processes	• Employers, Ministry of Health
• Retention processes	• Employers, professional associations, Ministry of Health, labour
• Redeployment and retirement processes	• Employers
• Career counselling and marketing of professional careers	• Employers, Ministries of Education, Skills Development
• Retraining	• Employers, Ministry of Colleges and Universities
• Immigration incentives and regulation	• Immigration Canada, Ministry of Health
• Collective agreements	• Employers, labour
• Job design	• Employers
Governance and Regulation	
Professional	
• Scope of practice	• Provincial legislation, professional colleges
• Professional licensure	• Professional colleges
• Competency testing	• Professional colleges
Service Delivery	
• Institutions, Agencies, and Other Organizations	• Provincial legislation
Funding and Service Delivery	
• Remuneration levels	• Employers, funding agencies/ministries
• Remuneration methods	• Ministries of Health, Community and Social Services, labour, providers, employers
• Practice location incentives and regulations	• Ministries of Health, Community and Social Services
• Service delivery models	• Providers, Ministries of Health, Community and Social Services

RECOMMENDATIONS

Recommendation #1 *(pages 7,8)*

The Health Care System Committee recommends that health human resources planning in Ontario should be guided by the following goal and principles:

The goal of human resources planning in health is to achieve the most effective, flexible and cost-efficient use of our key asset, people, in order to realize Ontario's vision of health.

Health human resources planning should be guided by the following principles:

1. Human resources planning is *the most important component of strategic planning* in health care and a fundamental component of health policy.
2. *Human resources planning should be driven by health goals.* The implication is that planning begins to be driven by health outcomes based on the health needs of the population.
3. The health human resources planning process should be *dynamic and flexible* enough to anticipate issues, monitor trends and respond effectively in a rapidly changing environment.
4. Human resources *substitutions* will need to occur between, and within health care provider groups in order to achieve quality health service with maximum productivity. The most appropriate skill set required at the least cost to achieve the best patient outcome is the most desirable result of such substitutions.
5. Future efforts in health care should be driven by *better utilization of our current resources.*
6. Commitment to *continuous improvements in health care* is essential and assumes that not all health care services performed today are appropriate or equally effective.
7. Health human resources planning should be *open to public scrutiny*, be consultative and have multipartite involvement.
8. Provincial development of a strategic human resources planning capability must be *strongly linked to federal and regional planning. Ontario has an opportunity to play a leadership role* in developing a national strategy for health human resources planning.

Recommendation #2 *(pages 4,5)*

Education and Training:

Educators must develop curricula more directly oriented to their communities and the population health needs of the communities they serve. Measures should be taken to assist the development of a health intelligence capability to link epidemiological data, cost, and delivery systems to health outcomes and human resources planning with a particular community college or university.

Additional training sites in community and multidisciplinary practice settings will give students experience in a full range of delivery systems.

Retraining strategies will need to be developed to facilitate the potential re-assignment of some health care workers.

Measures should be taken to explore the development of generic, basic educational building blocks for all health professionals as well as other measures to build equity and co-operation among health care providers.

Health system delivery research should be enhanced and focus on such issues as alternative delivery methods, cost and resource management, health outcomes and total quality management practices.

Recommendation #3 *(pages 5,6)*

Quality Management and Productivity:

Ontario must build its own unique approach to quality management and productivity practices in partnership with stakeholders. The Premier's Council on Health Strategy and stakeholder groups including the Ministry of Health should explore options to effectively institutionalize these practices.

Professional colleges/regulatory boards and associations should develop a more collaborative and expanded role in promoting total quality management practices and increased productivity among their members.

Recommendation #4 *(pages 9,10)*

The locus of provincial responsibility for health human resources planning and management should be a lead minister reporting to an appropriate cabinet committee. As part of its mandate, the cabinet committee should be responsible for health resources and the monitoring of provincial health goals and objectives. Ministers who should be members of this committee are: Health, Community and Social Services, Colleges and Universities, Treasury and Economics, Labour and such other ministries that the government may deem appropriate.

Recommendation #5 *(page 10)*

A new Health Human Resources Planning Agency (HHRPA) should be established with responsibility for developing a strategic health human resources planning and implementation capacity in Ontario. The agency's mission, mandate and reporting relationships should be established by legislation and it should receive sufficient funds to carry out its mission.

Recommendation #6 *(pages 10,13)*

Reporting Relationship:

The HHRPA should report to the cabinet committee via a lead minister of a pivotal central agency of government such as Management Board of Cabinet.

Recommendation #7 *(page 12)*

Mission:

The mission of the HHRPA is to achieve the most effective, flexible and cost-efficient use of our key asset, people, in order to realize Ontario's vision of health.

Recommendation #8 *(page 12)*

Mandate:

The primary mandate of the HHRPA is to develop a strategic human resources planning and management capability for health care.

The HHRPA will then recommend to the government its best advice on human resources policy directions in health.

The HHRPA should build partnerships at all levels to facilitate adoption of its strategic advice and implementation strategies, and to translate that advice into management strategies.

The HHRPA will publish an annual public report summarizing the results of its planning analysis, recommendations and evaluation of the implementation of its previous recommendations.

Recommendation #9 *(page 12)*

Structure:

The HHRPA will be directed by a council which meets at least four times a year. The HHRPA council should be chaired by an individual with an impartial background. The chairperson should serve in this position on a full-time basis.

A maximum of 20 council members should be appointed to a three year term with one possible renewal of term. The appointments should allow for rotational change. The council will be a multipartite body and have representation from the following groups:

- consumer/public interest representatives;
- employers representing traditional and alternative delivery settings;
- health professions and occupations including labour representation to a maximum of 25 per cent of the total membership;
- health educators including representation from health science centres, community colleges and other health education programs to a maximum of 20 per cent of the total membership;
- senior ministry representatives from key ministries including Health, Community and Social Services, Colleges and Universities, Labour and such other ministries that the government may deem appropriate to a maximum of 25 per cent of the total membership;
- one member of the proposed Ontario Training and Adjustment Board (OTAB);
- one member with strategic human resources planning expertise; and
- the above members would reflect a regional representation from across the province.

The HHRPA should have a secretariat responsible for identifying planning issues, analyzing data, preparing the annual report, and supporting the work of the council. Mechanisms should be established at the staff level to ensure co-ordination of the work of the HHRPA with broader scope activities such as the proposed Ontario Training and Adjustment Board (OTAB).

Recommendation #10 *(pages 16 to 21)*

Process:

The HHRPA should take the necessary steps to implement the needs-based planning framework and to begin to co-ordinate and ensure that the necessary data is developed and available for use.

The HHRPA will recommend actions for the application of relevant policy levers to achieve a better mix, use and distribution of human resources. The recommendations should identify who is responsible for the policy levers and who should operate them. The recommendations should specify time frames for implementation. Evaluation procedures on the effectiveness of the interventions should be identified at the time the recommendations are made.

The HHRPA will recommend human resources policy directions in health.

The HHRPA will recommend implementation strategies for the policy directions.

The HHRPA will prepare an evaluation plan within the first year of its operation.

The strategic human resources planning process outlined in this report should occur at both the provincial and the regional levels. The HHRPA will be responsible for identifying goal-driven human resources requirements balanced against the identification of key issues that inhibit the flexible use of all health human resources.

APPENDIX 1
THE PREMIER'S COUNCIL ON HEALTH STRATEGY – MANDATE

In order to fulfil its mandate, the Council will be expected to:

1. Select specific goals to achieve the improved health of Ontario's residents and establish specific targets and priorities which can be measured, evaluated and implemented.
2. Recommend specific public policy initiatives which are required to improve the health of Ontario's residents and which are beyond the traditional jurisdiction of the formal health care system.
3. Identify initiatives to develop public policy which emphasizes health promotion, disease prevention and community alternatives to institutional care.
4. Recommend innovative approaches to health care which are sensitive to the diverse needs of the province and which foster personal responsibility for health, the appropriate use of resources by individuals and health professions, and which enhance linkages between health and related human services.
5. Advise and assist the Ministry of Health in establishing the criteria and priorities to guide the allocation of the Health Innovation Fund and monitor the performance of projects approved for funding.

APPENDIX 2
THE HEALTH CARE SYSTEM COMMITTEE – MANDATE

TERMS OF REFERENCE

To address the future requirements of the health care system in Ontario, the Council established a subcommittee to provide Council with specific strategies for action. The terms of reference of the Health Care System Committee are as follows:

1. To recommend the key issues that Council will address for the future development of Ontario's health care system based on a review of the major directions outlined in the Evans, Spasoff and Podborski reports and on other factors identified by the committee.
2. To develop these issues into a plan for how the health care system ought to be developing, in keeping with the mission and priorities of the Premier's Council on Health Strategy and the three reports received by the government.
3. To recommend both immediate and longer term initiatives that Council should undertake to achieve visible and tangible results.
4. To recommend to Council options for:
   a. funding and incentives that will assist in implementation of the plan;
   b. manpower strategies for training and regulating current and future health practitioners as it relates to the plan;
   c. pilot projects for funding under the Health Innovation Fund to test and evaluate new delivery methods in support of the plan; and
   d. improving local planning and participation in the implementation of new programs and services.
5. To evaluate the pilot projects and develop specific means for an orderly introduction into the health care system.

APPENDIX 3
CONSULTANTS

Several proposals were received and the proposals were assessed by committee in terms of their proposed methodology, scope, understanding of the issues and composition of the consulting team. Based on this assessment, three firms were interviewed and the Price Waterhouse team was selected to conduct the study.

TIMELINE

The project began on February 1, 1990 and the final report was received in July 1990. The Health Care System Committee met regularly with the consultants throughout the duration of the project to review findings and to give direction.

Members of the Price Waterhouse Consulting Team

Neil Stuart
Deborah Leach
Roberta Carefoote
Morris Barer
Geoffrey Anderson
Arminee Kazanjian
Peggy Stratton
Leonard Rutman

Members of the Expert Panel Internal to the Price Waterhouse Study

Mr. Orvill Adams
Curry Adams and Associates

Dr. Geoffrey Anderson
University of British Columbia

Dr. Morris Barer
University of British Columbia

Ms. Roberta Carefoote
Price Waterhouse

Dr. Morley Gunderson
University of Toronto

Ms. Susan Hyatt
Premier's Council on Health Strategy

Dr. Arminee Kazanjian
University of British Columbia

Ms. Deborah Leach
Price Waterhouse

Ms. Frances Picherack
Consultant

Mr. John Ronson
Blake, Cassels and Graydon

Dr. Leonard Rutman
Price Waterhouse

Dr. Neil Stuart
Price Waterhouse

Dr. James Walker
The Walker Group Inc.

Mr. Lorne Zon
Metropolitan Toronto District Health Council

APPENDIX 4
CONSULTATION

Due to the nature of the study and the broad stakeholder interest in the outcome, the committee directed that there be a broad consultative approach taken. As a result, extensive consultation processes were built into the study:

Call For Position Papers

Ninety stakeholder groups were invited to submit a brief position paper commenting on:

- what should be done in health human resources planning;
- who should be responsible; and
- what mechanisms should be used for implementing planning decisions.

(Forty-three position papers were received.)

Stakeholder Conference

In April 1990, 145 organizations/individuals representing health care providers, educators, employers, government, consumers, labour, district health councils and professional colleges were invited to attend a one-day session. More than 90 representatives attended the session.

Participants were asked to assist in defining the mandate for a planning process and to focus on the issue of responsibility for, and participants in, health human resources planning for Ontario.

STAKEHOLDER CONFERENCE - APRIL 1990

INVITED PARTICIPANTS

Professional Associations/Organizations

Association of Administrative Respiratory Therapists
Association of Hearing Instrument Practitioners in Ontario
Association of Independent Physicians of Ontario
Association of Ontario Midwives
Association of Registered Dental Technologists
Cardiology Technologists Association of Ontario
Denturist Association of Ontario
Emergency Nurses Association of Ontario
Gerontological Nurses Association (Ontario)
Medical Reform Group of Ontario
Task Force on the Implementation of Midwifery in Ontario
Midwives Collective of Toronto
Nurse Practitioners Association of Ontario
Ontario Association of Dispensing Opticians
Ontario Association of Home Care Respiratory Therapists
Ontario Association of Medical Radiation Technologists
Ontario Association of Optometrists
Ontario Association of Pathologists
Ontario Association of Professional Social Workers
Ontario Association of Registered Nursing Assistants
Ontario Association - Speech Language Pathologists and Audiologists
Ontario Athletic Therapists Association
Ontario Chiropractic Association
Ontario Dental Association
Ontario Dental Hygienists Association
Ontario Dental Nurses and Assistants Association
Ontario Dietetic Association
Ontario Massage Therapists Association
Ontario Medical Association
Ontario Occupational Health Nurses Association
Ontario Osteopathic Association
Ontario Pharmacists Association
Ontario Physiotherapy Association
Ontario Podiatric Medical Association
Ontario Psychiatric Association
Ontario Psychological Association
Ontario Society of Clinical Perfusionists
Ontario Society of Chiropodists
Ontario Society of Clinical Chemists
Ontario Society of Medical Technologists
Ontario Society of Nutritionists in Public Health
Ontario Society of Occupational Therapists
Ontario Society of Public Health Dentists
Professional Association of Interns and Residents of Ontario
Registered Nurses' Association of Ontario
Respiratory Therapy Society of Ontario

Professional Colleges/Regulatory Boards

Board of Directors of Chiropractic
Board of Directors of Masseurs
Board of Directors of Physiotherapy
Board of Ophthalmic Dispensers
Board of Regents of Chiropody
Canadian Board for Certification of Prosthetists and Orthotists
College of Family Physicians of Canada - Ontario Chapter
College of Nurses of Ontario
College of Optometrists of Ontario
College of Physicians and Surgeons of Ontario
Governing Board of Dental Technicians
Governing Board of Denture Therapists
Interim Regulatory Council on Midwifery
Ontario Board of Examiners in Psychology
Ontario College of Certified Social Workers
Ontario College of Occupational Therapy
Ontario College of Pharmacists
Ontario Council on Therapeutic Recreation
Royal College of Dental Surgeons of Ontario

Health Educators

Council of Ontario Faculties of Medicine
Council of Ontario Universities
Ontario Council of Teaching Hospitals
Toronto Health Educators Association
University of Western Ontario/Northern Outreach Program

Agencies/Employers

Chronic Care Hospitals for Ontario
Association of Local Official Health Agencies (Ontario)
Association of Nurse Executives of Metropolitan Toronto
Association of Ontario Health Centres
Canadian Red Cross Society
Hospital Council of Metropolitan Toronto
Meals on Wheels of Ontario Inc.
Nursing Executive Committee of the Nursing Administration Section (OHA)
Ontario Association of Non-Profit Homes and Services for Seniors
Ontario Association of Visiting Homemaker Services
Ontario Home Care Programs Association
Ontario Hospital Association
Ontario Long-Term Residential Care Association
Ontario Nursing Home Association
Ontario Public Health Association
Association of District Health Council Chairmen
Queensway General Hospital (Toronto)
Saint Joseph's General Hospital (Elliot Lake)
Saint Elizabeth Visiting Nurses Association of Ontario
Saint Elizabeth Visiting Nurses Association of the Diocese of Hamilton
St. John Ambulance
University Hospital (London)
Victorian Order of Nurses (Ontario)

Labour Groups

Canadian Union of Public Employees
Ontario Nurses Association
Ontario Public Service Employees Union

Government

French Language Health Services, Ministry of Health
Health Programs Division, Ministry of Health
Health Manpower Planning, Ministry of Health
Policy Development Branch, Ministry of Health
Professional Relations Branch, Ministry of Health
Health and Welfare Canada
Ministry of Colleges and Universities
Ministry of Labour
Ministry of Northern Development and Mines
Office of the Premier
Office for Disabled Persons
Ontario Council of Regents for Colleges of Applied Arts and Technology
Ontario Council on University Affairs
Ontario Women's Directorate
Strategic Planning and Intergovernmental Relations, Ministry of Community and Social Services
Task Force on Long Term Care

Other

Catholic Health Association of Ontario
The Pharmaceutical Inquiry of Ontario
Metropolitan Toronto Board of Trade
Centre for Industrial Relations, University of Waterloo
Comprehensive Health System Planning Committee for London and Southwest Region
Northern Health Human Resource Committee (Advisory Committee to the Minister of Health, Ontario)
Task Force on the Use and Provision of Medical Services
Dr. Paul Ziter, District Health Council Member
Auxiliary Bishop of London
Ms. Maureen Quigley, Maureen Quigley and Associates

"From Vision to Action" Alumni

Mr. Vickery Stoughton, President, The Toronto Hospital
Dr. Sandy MacPherson, McMaster University
Ms. Jennifer Ritchie
Mr. Peter Ellis, President, Sunnybrook Medical Centre
Ms. Brenda Singer, Executive Director, Progress Place
Mr. John Butler, Executive Director, Peel District Health Council
Dr. Abbyann Lynch, Director, Westminster Institute

Health Care System Committee

Mr. Roy Aitken, Chair
Mr. John Carter
Ms. Glenna Cole Slattery
Dr. Martin Barkin
Sister Alice McEvoy
Mr. Jim McIntyre
Ms. Shanthi Radcliffe
Ms. Eleanor Ross
Dr. Hugh Scully
Dr. Mark Smith
Mr. Jay Kaufman
Mr. Michael McEwen
Ms. Susan Hyatt (staff)
Dr. Terry Sullivan (staff)

Questionnaire

A follow-up, mail-in questionnaire was distributed at the conference and mailed to those who did not attend.

The questionnaire asked stakeholders a series of questions on: the nature and extent of health human resources planning that should be considered for Ontario; possible organizational structures; whether the mandate should include the authority to implement changes recommended; participants and their roles; the data and information required; mechanisms to ensure that the public interests are represented; and challenges in implementing a health human resources planning process.

Consultation with Council/Commission Representatives and Government Officials

In May 1990, representatives of health councils/commissions from British Columbia, Quebec, Alberta and Nova Scotia, senior representatives of relevant Ontario ministries and the government, members of the Health Care System Committee, key informants, Chairs of other Council committees and staff of the Premier's Council on Health Strategy met to review and test the preliminary findings of the study and to explore other suggestions. A list of those attending the consultations follows:

CONSULTATION ON THE HEALTH HUMAN RESOURCES PLANNING STUDY - MAY 1990

INVITED PARTICIPANTS

Mr. Roy Aitken
Chair, Health Care System Committee
Premier's Council on Health Strategy

Dr. Martin Barkin
Member, Health Care System Committee
Premier's Council on Health Strategy

Mr. John Carter
Member, Health Care System Committee
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Sister Alice McEvoy
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Mr. Jim McIntyre
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Mrs. Marguerite Ford
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Mr. Neil Stuart
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Ms. Deborah Leach
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Ms. Frances Picherack
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APPENDIX 5
A CASE STUDY

NURSE PRACTITIONERS – A CASE STUDY DEMONSTRATING HOW TO ACHIEVE AN APPROPRIATE MIX, USE AND DISTRIBUTION OF HUMAN RESOURCES

Nurse practitioners (NPs) provide an example of a human resources substitution issue. The services of nurse practitioners can be substituted for some activities of family physicians in order to deliver quality service with the most appropriate skill set required and at less cost to the system.

Using 1980 data, F.T. Denton and colleagues at McMaster University "calculated a saving of 10-15 per cent of total medical costs or 16-24 per cent of ambulatory costs had NP time been substituted for physician time" in providing those services where NPs could substitute effectively. [2]

In this case study, the committee has identified policy levers that could address the NP substitution issue. Possible actions to remove barriers that impede the co-ordinated function of those policy levers are also suggested.

Nurse practitioners are registered nurses who have advanced clinical knowledge and expertise and a wide range of clinical responsibilities, including client assessments, the delivery of health care and the follow-up of patients.

Although there has been some debate about whether a nurse practitioner must work under the supervision of a physician and whether he or she is a "physician-replacement" or a "physician-complement," research literature, for the most part, has concluded that the nurse practitioner, working with physician supervision is in a "physician-replacement" role. In a "physician-replacement" role, the nurse practitioner performs functions "such as detailed physical assessment and health history, management of routine minor illnesses, management of perinatal and postnatal care and well-child care." In a "physician-complement" role the nurse practitioner functions as an added resource to the patient population, focusing on health teaching, counselling, monitoring of chronic illness and related counselling and developing programs for groups of patients with similar needs for health promotion and teaching." [3]

HISTORY

In the early 1970s, two nurse practitioner programs were established in Ontario. One was the program for nurses in primary care at McMaster University and the other program was at the University of Toronto. The University of Toronto program was a pilot project in conjunction with the Hospital for Sick Children to provide nurses for a northern nursing station at Sioux Lookout. In the second year of the program the University of Toronto decided to experiment and add some nurses who worked in urban settings as well as those nurses who were going to be in the northern nursing stations.

The last education programs for NPs were discontinued in Ontario in 1983.

W.O. Spitzer sums up the history of nurse practitioners as follows:

> "The promise that the nurse practitioner movement held in the early 1970s for better quality and more balanced primary health care, better access for the disadvantaged, containment of health-service costs and a more rational deployment of health manpower is largely unfulfilled." [4]

ANALYSIS

At least 14 randomized controlled trials have been conducted to evaluate nurse practitioners (three Canadian, 11 American). These trials have evaluated the following variables:

- safety and effectiveness
- quality of care
- patient outcomes
- economic implications
- job satisfaction
- client satisfaction.

Some methodological limitations to the studies were identified.

CONCLUSIONS

Nurse practitioners who have substituted for family physicians in some of the activities identified above have proven to be safe, equally or more effective than physicians, accepted by clients, and cost effective.

WHAT ARE THE CURRENT BARRIERS TO THE USE OF NURSE PRACTITIONERS?

Human Resources Planning and Supply

- No educational program/training for NPs in place.
- Physician surplus. In areas with a physician surplus, it is difficult to demonstrate a need for NP substitutes unless cost efficiency factors are introduced.

Governance and Regulation

- Regulatory limitations on the allowable practice role of NPs.
- Some nurses showed a preference for "physician-complement" instead of a "physician-replacement" role. (Spitzer)

Funding and Service Delivery

- Remuneration levels and methods. There was no appropriate mechanism for "remuneration recognition" of the NPs work in Ontario.
- Added cost to the system with "complement" role.
- Financial disadvantages to physicians who employed NPs. Disadvantages included lower rates of physician utilization, higher salaries with additional overhead expenses for nurse practitioners and OHIP billing restrictions where NPs were not allowed to bill OHIP unless the patient was seen by a family practitioner.[5]

Additional Barriers

- Undetermined role for a variety of practice settings.
- Lack of consumer lobby. A contrasting example is midwifery with a strong consumer lobby.

HOW TO STIMULATE ACTION TO ACHIEVE THE RIGHT MIX, USE AND DISTRIBUTION OF HUMAN RESOURCES

Nurse practitioners can be substituted for family physicians in some of the activities noted above by matching quality service delivery with a more appropriate skill set at reduced cost to the system. The following table identifies barriers to change, the corresponding policy levers, who has responsibility for the policy levers and possible actions to remedy the barriers. While a great deal more analysis is required this information nevertheless serves as an illustration of what could be done.

NURSE PRACTITIONERS (NPs)

Barrier Identifiers	Key Policy Levers	Responsibility	Possible Action
HUMAN RESOURCES PLANNING AND SUPPLY			
• No NP training program	• Funding for training	• Ministry of Health & Ministry of Colleges and Universities	• Fund training programs for NPs
• Physician surplus	• Enrolment levels for physicians	• Institutes for higher education	• Decrease enrolment levels for physicians (in family practice)
• To increase supply of NPs	• Recruitment processes	• Employers	• Recruit globally • Bring in licensed practitioners e.g., U.S.
GOVERNANCE AND REGULATION			
• Regulatory limitations on allowable practice	• Scope of practice	• Provincial legislation & professional colleges	• More flexibility with the proposed Health Professions Regulations Act
• Some nurses show preference for "physician-complement" role	• Curricula in nursing programs	• Institutes for higher education	• Changes to traditional education model
FUNDING AND SERVICE DELIVERY			
• Remuneration levels →		• Employers, funding agencies/ministries	• Develop appropriate levels
• Remuneration methods →		• Ministry of Health	• Develop appropriate methods that encourage substitution of nurse practitioners for some activities of family physicians
• Financial disadvantage to physicians who employed NPs.	• Practice location incentives and regulations	• Ministry of Health	• Place more NPs in alternative delivery setting

END NOTES

1. The OTAB was recently proposed by the Premier's Council (on Industrial Competitiveness) to oversee the funding and delivery of workplace training and adjustment programs in Ontario, with equal representation by labour and management.
2. Mitchell A. Evaluation of Midwives and Nurse Practitioners in the Delivery of Primary Health Care. In *Research and the Health Policy Process*, the proceedings of the 2nd Annual Health Policy Conference, Hamilton, Ontario, 1989, p. 238.
3. Ibid., p. 240.
4. Ibid., p. 241.
5. Ibid., p. 238 - 239.